STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
EMPLOYMENT DEVELOPMENT DEPARTMENT

# NOTICE OF STATUS CHANGE

**TO:** NAME: | OFFICE NUMBER:

CASE NAME: | NUMBER: | WORKER NO.:

☐ AFDC - INCOME MAINTENANCE UNIT ☐ EDD - JOB SERVICE

APPLICANT/RECIPIENT NAME | SSA NO.

Please check the status and complete the information which applies to the above applicant/recipient.

**FROM:** AFDC - INCOME MAINTENANCE UNIT:

- ☐ Denied AFDC, date _____
- ☐ Discontinued, date _____
- ☐ Exempt from work registration, date _____
- ☐ Medical exemption requested, date _____

Confirm within 30 days:

- ☐ Approved, date _____
- ☐ Denied, date _____

☐ Other (change of address, etc., - See comments)

**FROM:** EDD - JOB SERVICE:

- ☐ Did not comply with work registration requirements.
- ☐ Employed, beginning date _____
  - _____ Hours per ☐ Week ☐ Month
  - _____ Pay rate per ☐ Hour ☐ Week ☐ Month

JOB TITLE

EMPLOYER NAME

ADDRESS STREET

CITY ZIP CODE

TELEPHONE

☐ Other (See comments)

COMMENTS

FROM: NAME (PLEASE PRINT) | TELEPHONE NO. | DATE

CA 331/333 (11/99) RECOMMENDED FORM

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